2018 PRECISION DIAGNOSTICS PATIENT ASSISTANCE PROGRAM APPLICATION

Precision Diagnostics is committed to treating all patients equitably, with dignity and respect regardless of the patient's health care insurance benefits or financial resources. Precision Diagnostics works hard to help patients address any financial responsibilities they may have to pay for our laboratory services in a way that is fair and sensitive to their circumstances. Consistent with California and federal law, Precision Diagnostics has instituted this Patient Assistance Program to help patients who find themselves unable to pay the entire amount of the lab testing due to financial hardship, as determined under Federal Poverty Guidelines.

Eligible uninsured or underinsured patients may apply for a Financial Hardship Discount to the Patient Cash Price of Precision Diagnostics lab testing services by completing and signing this Application Form. Eligible Patients are encouraged to apply for a Financial Hardship Discount prior to making any payment to their account. As part of the Patient Assistance Program, Precision Diagnostics will reevaluate all eligible patients at least annually. Precision Diagnostics reserves the right to request that any eligible patient submit any supporting documentation for proof of eligibility and/or continuing eligibility. The amount of Financial Hardship Discount will be determined based on Federal Poverty Guidelines – for 2018, the Financial Hardship Discount will be calculated based on income.

To be eligible for a Financial Hardship Discount:

- ☐ **You must be uninsured or underinsured for the Precision Diagnostics lab testing services.**
- ☐ **Precision Diagnostics must have received a valid order for Precision Diagnostics lab testing services from your treating healthcare provider confirming the testing services are medically necessary for your treatment.**
- ☐ **Your household income must be at or below 300% of current Federal Poverty Guidelines.**
- ☐ **You must complete and sign this Application with the following information:**

PATIENT NAME: _____	**YOUR STATEMENT NUMBER:** _____
PATIENT DOB: _____	**YOUR DATE(S) OF LAB SERVICE:** _____
HOME ADDRESS: _____	**TOTAL ANNUAL HOUSEHOLD INCOME: $**_____
_____	**NUMBER OF PERSONS IN HOUSEHOLD:** _____
TELEPHONE: _____	**EMPLOYER (IF ANY):** _____
For Internal use only	**ADDRESS:** _____
EPI Number: _____	_____
Percentage Approved _____**% Initials** _____ **Denied**	

I HEREBY AFFIRM THE ABOVE INFORMATION IS TRUE AND CORRECT. I HEREBY AGREE THAT I WILL NOTIFY PRECISION DIAGNOSTICS OF ANY MATERIAL CHANGE IN MY FINANCIAL CIRCUMSTANCES, WHICH INCLUDES A CHANGE IN HOUSEHOLD INCOME OR INSURANCE. I HEREBY ATTEST THAT I AM NEITHER RELATED TO, NOR EMPLOYED BY, THE PHYSICIAN WHO ORDERED THE TESTING.

Signature: _____ **Date:** _____

Please return completed form to: 6755 Mira Mesa Blvd, Suite 123 Box 153, San Diego, CA 92121-4392

Questions about the Precision Diagnostics Patient Assistance Program should be directed to Precision Diagnostics' Billing Department at 1-855-529-9560 Fax: 619-374-7469